

Indiana University Speech-Language & Hearing Clinics REGISTRATION FORM

Hearing Clinic <input type="checkbox"/>			Speech-Language Clinic <input type="checkbox"/>			
PATIENT INFORMATION						
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> No title	Marital Status: Single <input type="checkbox"/> Spouse/Domestic partner <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Street Address:			Home Phone# : ()		Cell Phone # : ()	
City:		State:	Zip Code:	E-mail Address:		
Preferred Method of Communication: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone For this number, please check the appropriate box: <input type="checkbox"/> OK to leave a message with detailed information <input type="checkbox"/> Leave a message with call-back number only <input type="checkbox"/> Secure email			Secondary Method of Communication: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone For this number, please check the appropriate box: <input type="checkbox"/> OK to leave a message with detailed information <input type="checkbox"/> Leave a message with call-back number only <input type="checkbox"/> Secure email			
Occupation:		Employer:		Employer Phone # : ()		
Referred to clinic by (Please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home Phone # : ()	Cell Phone # : ()

INSURANCE INFORMATION			
COMPLETED CLAIM FORMS AVAILABLE AS A COURTESY BUT WILL NOT BE SUBMITTED DIRECTLY TO INSURERS			
(Please give your insurance card to the receptionist)			
Person responsible for bill:	Birth Date:	Address (if different):	Home Phone # : ()
Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation:	Employer:	Employer Address:	Employer Phone # : ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate primary insurance company:			

Subscriber's Name:	Insurance ID #:	Birth Date:	Group #:	Policy #:	Co-payment: \$
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):	Subscriber's Name:	Birth Date:	Group #:	Policy #:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IU BURSAR INFORMATION

Bill to your bursar account? (IU students only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Student ID#:
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CONSENT AND AUTHORIZATION

If I qualify for an upcoming research investigation, please inform me so that I may consider participating	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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My signature below confirms that I have reviewed the "Notices of Privacy Practices" and its explanation of how the IU Speech-Language & Hearing Clinics will use my personal health information in relation to treatment, payment and healthcare operations, as well as my rights regarding the management of this information.

I also authorize the IU Speech-Language & Hearing Clinics, their agents, and employees and students to provide evaluation and treatment services. I understand that the IU Speech-Language & Hearing Clinics are an educational institution and I agree that student clinicians (in training to be speech pathologists and audiologists) may provide care under the supervision of licensed speech pathologists and audiologists.

I understand that the IU Speech-Language & Hearing Clinics may provide me with completed insurance claim forms should I choose to submit claims to an insurance carrier. I authorize communication of my health information between the IU Speech-Language & Hearing Clinics and my insurance company. I further understand that I am fully responsible for payment of services provided in this office for myself or my dependents. I understand that if I do not make payments in a timely manner for services received from the IU Speech-Language & Hearing Clinics, the Clinics may pursue collection of any past due balance through the use of an collection agency or an attorney. In the event this becomes necessary, I understand that I will be responsible for any and all finance charge(s), collection charge(s), and/or attorney fee(s) that may result.

Patient/Guardian signature **Date**

Return form to:

IU Speech-Language & Hearing Clinics
 2631 East Discovery Parkway
 Bloomington, IN 47408